STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	ETED
		15G652	B. WIN	G		12/31/	2013
NAME OF F	PROVIDER OR SUPPLIE	R	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					SEPH ST		
DEVELOPMENTAL SERVICES INC				GREEN	ISBURG, IN 47240		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K010000							
	A Life Safety C	ode Recertification	I KO1	10000			
			KUI	10000			
		ducted by the Indiana					
	State Departmer						
	accordance with	42 CFR 483.470(j).					
	G D 1/	7/21/12					
	Survey Date: 12	2/31/13					
	E 114 M 1	001100					
	Facility Number						
	Provider Numbe						
	AIM Number:	100233930					
	*	Bugni, Life Safety					
	Code Specialist						
		ety Code survey,					
	Developmental	Services Inc. was found					
	not in compliance	ce with Requirements					
	for Participation	in Medicaid, 42 CFR					
	Subpart 483.470	(j), Life Safety from					
	Fire and the 200	0 edition of the National					
	Fire Protection	Association (NFPA)					
		Code (LSC), Chapter					
	· ·	sidential Board and Care					
	Occupancies.	Zacania Board and Cure					
	Coupanoies.						
	This one story fa	acility was fully					
	I	facility has a fire alarm					
	_	oke detection in the					
	l -						
		nmon living areas and					
		ke detectors in all client					
		The facility has a					
	capacity of 6 and	d had a census of 6 at the					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2014 FORM APPROVED OMB NO. 0938-0391

	DF CORRECTION IDENTIFICATION NUMBER:  15G652	A. BUILDING  B. WING	<u>01</u>	COMPLETED  12/31/2013			
	ROVIDER OR SUPPLIER PMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
	Calculation of the Evacuation Difficulty Score (E-Score) using NFPA 101A, Alternative Approaches to Life Safety, Chapter 6, rated the facility Slow with an E-Score of 1.76.  Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/02/13.  The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:						

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Event ID: TGGJ21

Facility ID: 001190

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPLETED
		15G652	B. WING			12/31/2013
			b. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER					
DEVELO	DMENITAL SEDVIC	ES INC			SEPH ST ISBURG, IN 47240	
DEVELOPMENTAL SERVICES INC				GREEN	13BURG, IN 47240	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	483.470(j)(1)(i) LIFE SAFETY CO PROMPT Where an automatinstalled, for either coverage, the syst Section 9.7, 33.2.3 alarm system in at The adequacy of the documented to the jurisdiction.  Exception No. 1: In facilities, an automatic accordance with North the Installation of Sand two Family Downs, is permitted are not required in sq. ft., provided the finished with lath a providing a 15 minusers. Section No. 2: Now the Installation capabination automatic sprinkle with NFPA 13, State of Sprinkler System are not required in sq. ft and in bathrost., provided that swith lath and plast 15 minute thermal exception No. 4: In evacuation capabination capabi	tic sprinkler system is a total or partial building tem is in accordance with 3.5.2 and activates the fire eccordance with 33.2.3.4.1. The water supply is a authority having a tem in accordance of the wellings and Manufactured ted. Automatic sprinkler system in accordance with sprinklers and Manufactured ted. Automatic sprinklers are closets not exceeding 24 tooms not exceeding 55 at such spaces are and plaster or materials the more prompt and slow the prompt and slow the prompt and slow are system is in accordance and are system is in accordance and are for the Installation tems, automatic sprinklers a closets not exceeding 24 tooms not exceeding 24 tooms not exceeding 24 tooms not exceeding 25 sq. such spaces are finished er or material providing a			CROSS-REFERENCED TO THE APPROPRIA	TE
		IFPA 13R, Standard for Sprinkler Systems in				

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Event ID: TGGJ21

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL	ETED
		15G652	B. WIN			12/31/	2013
NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC			<u>.                                      </u>	901 JOS	ADDRESS, CITY, STATE, ZIP CODE SEPH ST ISBURG, IN 47240		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		T	ID	DROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	· E	DATE
	· ·	pancies up to and Including eight, are permitted.					
	Exception No. 5: N	Not applicable					
	system is not requ	nitiation of the fire alarm lired for existing cordance with 33.2.3.5.5.					
	installed, for eithe coverage, the sys Section 9.7 and a system in accorda	tic sprinkler system is r total or partial building tem is in accordance with ctivates the fire alarm ance with 33.2.3.4.1. The vater supply is documented living jurisdiction.					
	Exception No. 1: N	Not Applicable					
	Exception No. 2: N	Not Applicable					
	evacuation capab automatic sprinkle with NFPA 13, Sta of Sprinkler Syste are not required ir sq. ft. and in bathr sq. ft., provided th finished with lath a	n prompt and slow ility facilities where an er system is in accordance andard for the Installation ms, automatic sprinklers a closets not exceeding 24 rooms not exceeding 55 at such spaces are and plaster or material nute thermal barrier.					
	evacuation capab including four stor accordance with N the Installation of Residential Occup	n prompt and slow ility facilities up to and ies in height, systems in NFPA 13R, Standard for Sprinkler Systems in bancies up to and Including eight, are permitted.					

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Event ID: TGGJ21

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	ER/CLIA (X2) MU		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED	
		15G652	B. WIN	G		12/31/	2013
NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC			•	901 JO	ADDRESS, CITY, STATE, ZIP CODE SEPH ST ISBURG, IN 47240		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	system is not requinstallations in accordance of the coverage, the system in accordance adequacy of the word to the authority has 33.2.3.5.2.  Exception No. 1: Note that the coverage is a system in accordance adequacy of the word to the authority has 33.2.3.5.2.  Exception No. 1: Note that the coverage is a system in accordance adequacy of the word to the authority has 33.2.3.5.2.  Exception No. 2: If evacuation capables is sprinkler system in 13D, Standard for Sprinkler Systems of the coverage is a system of the coverage in the coverage in the coverage is a system of the coverage in the coverage is a system of the coverage in the coverage is a system of the coverage in the coverage is a system of the coverage in the coverage is a system of the coverage in the coverage is a system of the coverage in the coverage is a system of the coverage in the coverage is a system of the coverage in the coverage is a system of the coverage in	tic sprinkler system is respectively total or partial building tem is in accordance with activates the fire alarm ance with 33.2.3.4.1. The vater supply is documented aving jurisdiction.  Not Applicable.  In slow and impractical illity facilities, an automatic in accordance with NFPA at the Installation of in One and Two Family inufactured Homes, with a supply, is permitted. All indictored closets are sprinklered. For are not required in acceding 55 sq. ft., provided are finished with lath and its providing a 15 minute.  Not Applicable.  Not Applicable.  In impractical evacuation is up to and including four systems in accordance with lard for the Installation of its in Residential or and Including Four					
			1				I

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CC	ONSTRUCTION 01	(X3) DATE ( COMPL		
11112 12111	15G652			LDING		12/31/		
			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE					
NAME OF P	PROVIDER OR SUPPLIER		901 JOSEPH ST					
DEVELO	DEVELOPMENTAL SERVICES INC			GREENSBURG, IN 47240				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
TAG		nd closets are sprinklered.		TAG			DATE	
	Automatic sprinkle bathrooms not exceed that such spaces a	create are sprinkered.  ers are not required in ceeding 55 sq. ft., provided are finished with lath and s providing a 15 minute						
	system is not requ	nitiation of the fire alarm lired for existing cordance with 33.2.3.5.5.						
		ation and interview, the	K01	S056	Contact will be made with	10	01/30/2014	
	facility failed to ensure 1 of 39 sprinkler heads in the facility were maintained.				Koorsen Fire & Security, the contracted fire system compared	nv.		
					requesting the missing sprinkler			
	•	es all sprinkler systems			escutcheon be replaced.			
	shall be inspected, tested, and				Koorsen will routinely inspect each facility for compliance with			
		cordance with NFPA			this and all regulations within	their		
		the Inspection, Testing, e of Water-Based Fire			control.Responsible for QA: S	SGL		
		ms. NFPA 25, 1-4.4			Division Manager			
	_	or occupant shall						
		or repair deficiencies,						
		r impairments found						
		g the inspection, test,						
		requirements of this						
	standard. Correc	etions and repairs shall						
	be performed by	qualified maintenance						
	personnel or a qu	ualified contractor. This						
	deficient practice	e could affect all clients						
	in the facility wh	o use the staff office.						
	Findings include	:						
	Based on observa	ation on 12/31/13 at						
	10:50 a.m. with o	client service worker#						
	•	e sprinkler in the center						
	of the room was	missing the sprinkler						

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Event ID: TGGJ21

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/29/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G652			LDING	O1	(X3) DATE ( COMPL <b>12/31</b> /	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  901 JOSEPH ST  GREENSBURG, IN 47240					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
K01S148	service worker # observation and a exit conference of p.m.  483.470(j)(1)(i) LIFE SAFETY CO Smoking regulation administration of boccupancies. 32 Based on observation facility failed to provide the provided where such as a suc	DE STANDARD  ns are adopted by the loard and care 2.7.4.1, 33.7.4.1  nation and interview, the provide a metal self closing cover for 1 moking is permitted. uires noncombustible mays or receptacles shall re smoking is permitted. Explains that self closing to which ashtrays can be made available where litted and should be ea. This deficient fect all clients in the	K01	S148	An approved container for the disposal of smoking materials be obtained and provided for u at this home. Each location w be checked to ensure complia in this area.Responsible for QASGL Manager	ise ill nce	01/30/2014	

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652	LDING	NSTRUCTION  01	(X3) DATE COMPL 12/31/	ETED
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE	-	
DEVELO	PMENTAL SERVIC	CES INC		SEPH ST ISBURG, IN 47240		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
	sand but lacked a	a metal container with a				
	self closing cove	er for discarded smoking				
	material. This w	as verified by client				
	service worker #	1 at the time of				
		acknowledged at the				
	exit conference of	on 12/31/13 at 12:05				
	p.m.					
						<u> </u>

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